

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-022029

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

5588

FILED JUN 3 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Normandy	
Length of stay in 1b 3 days		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hospital		d. STREET ADDRESS (If outside, give location) 7711 Augusta	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last William Glennon O'Connell			4. DATE OF DEATH Month Day Year May 26, 1963		
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4/17/1916	9. AGE (last birthday) 47	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Fitter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (City and state or country) St. Louis, Mo.	
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Dennis O'Connell		13b. MOTHER'S MAIDEN NAME Ellen Hogan	
14. NAME OF HUSBAND OR WIFE Loretta Wrobel		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) Yes W.W. #2		16. SOCIAL SECURITY NO. 5811	
17. INFORMANT John O'Connell		Address 7711 Augusta		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Encephalomalacia, right cerebral hemisphere 1 1/2 days DUE TO (b) Hemorrhage, right middle cerebral artery DUE TO (c) Hypoglycemia due to insulin overdose 1 year	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 5811		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 5811	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from May 24, 1963 to May 26, 1963 and last saw him alive on May 26, 1963 Death occurred at 2:25 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) John T. Lawton, M.D.		22b. ADDRESS 634 N. Grand Blvd.	
22c. DATE SIGNED May 27, 1963		22d. LOCATION (City, town, or county) St. Louis Mo.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5/29/63	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
24. FUNERAL DIRECTOR Allen Kelly		25. DATE RECD. BY LOCAL REG. MAY 27 1963	
ADDRESS 7267 Natural Bridge		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.	

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO.

VS 300  
Rev. 4/59

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*James H. Lammere*

Licensed Embalmer No.

*4142*

P. O. Address

*St Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.